SUBMIT COMPLETED FORM TO YOUR DEPARTMENT PERSONNEL AND/OR ATTENDANCE CLERK.

Do not send to DPA

STATE OF CALIFORNIA
GROUP LEGAL SERVICES INSURANCE PLAN

Underwritten by GuideOne Insurance, West Des Moines, IA

No money needed to enroll — Payroll deduction.

Gp. number: **10202**

SECTION A. Please type or complete in ballpoint pen. See privacy notice on back side.

1. Type of Action (Check one)

a. ☐ NEW ENROLLMENT – Complete sections A (1-6) and B (1&3)

b. ☐ CHANGE OF COVERAGE – Complete sections A (1-6) and B (1&3)

c. ☐ CANCEL COVERAGE– Complete sections A (1-6) and B (2A & B-3)

2. Social Security Number

3. Date of Birth

Month | Day | Year

4. Name in Full

First | Middle Initial | Last

5. Mailing Address

Number and Street

City | State | ZIP Code

6. Daytime Telephone Number

SECTION B. Please check appropriate box, read and sign.

1. ☐ I authorize deductions to be made from my salary to cover my share of enrollment in the State's Group Legal Services Insurance Plan as it is now or as it may be in the future with coverage as shown below:

Please check type of coverage to be elected and monthly premium amount (check one only).

a. ☐ **Individual $9.60/month**

b. ☐ **Family $16.95/month**

c. ☐ **Domestic partner, child of either partner, and/or domestic partnership $16.95/month***

*must provide a copy of the domestic partner certification (if not already on file in the employee's personnel file)

If you selected family coverage, please list spouse/domestic partner and unmarried dependent children below.

Name	Date of Birth	Name	Date of Birth

2. a. ☐ I elect to cancel the Group Legal Services Insurance Plan

b. Reason for cancellation: (optional)

3. Please read and sign.

Application is hereby made for coverage as indicated above for all persons listed hereon, subject to all terms and conditions of the contract for which application is made. I understand that coverage will not become effective until the date assigned by GuideOne Insurance, after approval of this application and that if the application is not approved, the amount of any premium submitted herewith will be returned to me. I certify that all information entered is true. I fully understand the waiting periods and limitations of the coverage for which I am applying.

In connection with my application for benefits through GuideOne Insurance, I hereby authorize my Employer as my agent to deduct the cost to me for such contract as it is now or as it may be in the future, from my wages or salary within the month prior to my effective date for the coverage I am electing. I further understand the premiums shown above include an administrative cost incurred by the State, which may be increased without prior notice.

Signature X _____ **Date** X Month / Day / Year _____

SECTION C. To be completed by agency personnel office. Note this section is audited by SCO.

1. Deduction code	2. Organization code	3. Deduction amount (Circle one)	4. Agency name	5. Date received in employing office Month / Day / Year
075	081	$9.60 or $16.95		

6. Bargaining Unit #	7. Agency code	8. Rept. unit code

9. Remarks–For newly eligible employee/status change(s)

10. Permitting event date Month / Day / Year

11. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only).

12. AUTHORIZED AGENCY SIGNATURE

I certify that authorization for payroll deductions signed by this employee and appointing the above-named company or organization as his/her agent is on file in this office.

Telephone ( ) –

(indicate if CALNET or give area code)

13. Effective date of coverage Month / Day / Year

WHITE AND YELLOW – TO CONTROLLER **PINK – RETAINED BY AGENCY** **GOLDENROD – TO EMPLOYEE FROM PERSONNEL OFFICE**

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